The Shrewsbury and Telford Hospital NHS Trust

Cover page	
Meeting	Trust Board
Paper Title	Quality Improvement Plan (QIP) update
Date of meeting	30/05/2019
Date paper was written	22/05/2019
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Executive Summary

In response to the Must Do and Should Do findings set out by the Care Quality Commission (CQC) in their November 2018 inspection report, the Trust has developed a Quality Improvement Plan (QIP). Progress is being made across all five Improvement Steering Groups (ISGs). All besides the Well-led ISG are reporting in two-weekly cycles ('sprints'). Owing to the nature of actions included in the Well-led improvement plan this is reporting on a monthly basis.

In addition to tracking action completion, key performance indicators (KPIs) have also been developed. These are to ensure that actions have the intended impact, and that taken together the actions are improving services overall, and the care provided to patients.

The approach to engagement with our patients, staff and system partners has also been developed. The Patient Experience Strategy guides our approach to patient engagement and is being refreshed. Around 80 engagement champions have volunteered to support staff engagement, and the Improving Together newsletter has been launched. We share progress with partners through a monthly Safety Oversight and Assurance Group.

A substantive programme management office (PMO) has been put in place, taking over from external support. Preparation for the next CQC inspection will also be undertaken to ensure that improvements, as well as future plans, can be clearly articulated.

The purpose of this paper is to:

1. **Inform and provide assurance** to the Board on the monitoring and implementation of the QIP.
2. **Inform and provide assurance** to the Board of the approach towards engagement with patients, staff and system partners.
3. **Note** the next steps to further embed and evidence delivery of continuous improvement ahead of the next CQC inspection and beyond.

Previously considered by	A summary of this paper has been presented at Quality and Safety Committee. This paper has been presented at the Executive Continuous Improvement Board.

The Board is asked to:

☐ Approve	☐ Receive	☑ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	RR1533 We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	*Is there a financial impact associated with the paper?*

Main Paper

Situation

At the 4 April 2019 Board meeting an update was provided on the development and implementation of the Quality Improvement Plan (QIP), to address the findings highlighted in the November 2018 Care Quality Commission (CQC) inspection report.

The approach to developing the QIP was set out in our '28-day response' to the CQC; this was accepted by the Board and our regulators. Plans have been in place since March, overseen by five Improvement Steering Groups (ISGs).

All besides the Well-led ISG are reporting in two-weekly cycles ('sprints'). Owing to the nature of actions included in the Well-led improvement plan this is reporting on a monthly basis. The Well-led improvement plan was approved by the ISG on 29 April 2019.

At the end of April, the latest full month for which reporting is available, 93 Must Do Root Causes and eight Should Do Root Causes were completed. This is over 75% of the forecast completion trajectory, a slight reduction from the 80% of trajectory completion achieved at the end of March. All actions that are off track are routinely escalated to a weekly Executive Continuous Improvement Board meeting, with supporting recovery plans. Any proposed changes to the plan are also reviewed and approved at this meeting.

We have confidence in the structures we have put in place, with actions being reviewed by fortnightly ISGs. Overall, 137 Must Do Root Causes are marked as on track. Risks to delivery are monitored and responded to through the Executive Continuous Improvement Board.

The impact and embeddedness of the QIP is measured through Key Performance Indicators (KPIs). These have been developed for all Must Do and Should Do Root Causes. High-level KPIs aligned across the five CQC domains for each ISG (Safe, Effective, Caring, Responsive and Well-led) have also been developed to measure overall improvement.

Our approach to engagement has also developed:

- Patient engagement is guided by the Patient Experience Strategy, which will be refreshed over the summer.
- Over 50 Engagement Champions (ECs) have also been recently appointed. The Trust recognises that the engagement of staff is critical to the provision of high-quality care and ECs will play a pivotal role in ensuring actions can be taken to enhance staff engagement.
- QIP progress is shared frequently with regulators and system partners on a monthly basis, through the Safety Oversight and Assurance Group (SOAG). This forum also provides system partners with an opportunity to provide feedback and offer support.

To support ongoing delivery and tracking of progress a substantive PMO team (the Improving Care PMO) has been put in place. This PMO will be responsible for the ongoing maintenance of QIPs and ensuring there is a consistent focus on how actions are leading to improvements in Trust performance. Reliance on external support has reduced as part of the scheduled handover of PMO activities. It is anticipated that further external support will be required to support CQC inspection preparation, to bolster the substantive team.

Background

The CQC's Inspection Report for the Trust was published on 29 November 2018. The Trust was found to be Inadequate in two domains (Safe and Well-led) and was rated overall as Inadequate. The CQC's 79 Must Do findings describe areas where the Trust must demonstrate improvement. A further 91 Should Do findings recommend additional areas for improvement.

Section 29A and Section 31 Notice letters were received ahead of publication of the final report in response to urgent concerns identified during the inspection requiring immediate action.

In response comprehensive improvement plans (the QIPs) were developed using the Situation, Background, Assessment, Recommendation (SBAR) approach with clear actions, accountabilities and trajectories agreed. QIPs were developed across five areas by Improvement Steering Groups (ISGs), who are now overseeing progress:

- Women's and Children's
- Unscheduled Care
- Scheduled Care
- Workforce
- Well-led

Note that the Well-led ISG oversees and improvement plan that is based upon the CQC key lines of enquiry (KLOE) and prompts for the Well-led domain in the assessment framework. This does, though, address findings included within the CQC inspection report and other external assessment.

The ISGs and the associated QIPs have been operationalised throughout March and April. Reporting on progress is undertaken by two-weekly cycles ('sprints'), with the exception of Well-led. For this QIP, there is a monthly reporting cycle. An Executive Continuous Improvement Board was established to oversee development and delivery of the plan and to hold ISGs to account though their Accountable Executives.

At the end of March, we had completed 52 Root Causes in total, representing a significant increase from the previous month, whilst also hitting our target of completing eight Must Do actions. This represented over 80% of the trajectory of Must Do Root Causes due for completion by that point.

Assessment

1. Must Do and Should Do QIP delivery against trajectory

This section of the paper provides a summary of the progress that has been made in completing the Root Causes and actions against them. This is a marker of progress of implementing changes that seek to address concerns identified. The following section describes the approach being taken to measuring the impact of these changes.

1a. Delivery against trajectory

At the end of April, the latest full month for which reporting is available, 93 Must Do Root Causes and eight Should Do Root Causes were completed, a significant uplift against the progress at the end of March. This is over 75% of the forecast completion trajectory, a slight reduction from the 80% of trajectory completion achieved at the end of March.

This progress is shown, broken down by ISG, in the charts below; Figure One shows progress for the Must Do Root Causes by month, Figure Two for the Should Do Root Causes by month:

Figure 1: Must Do Root Cause completion, by month, selected months.

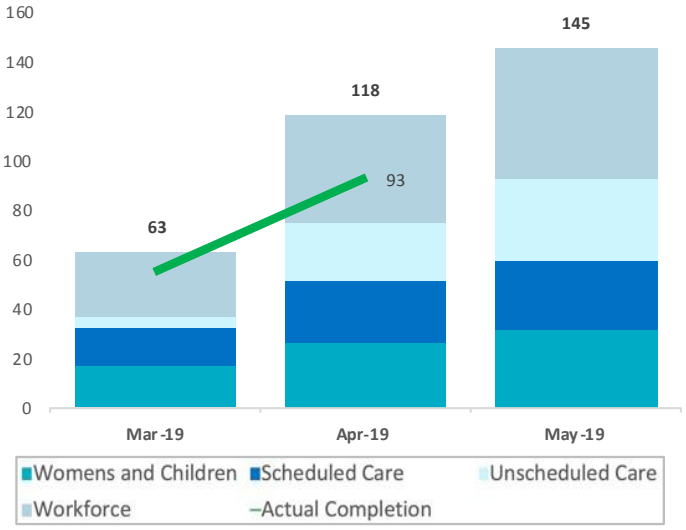
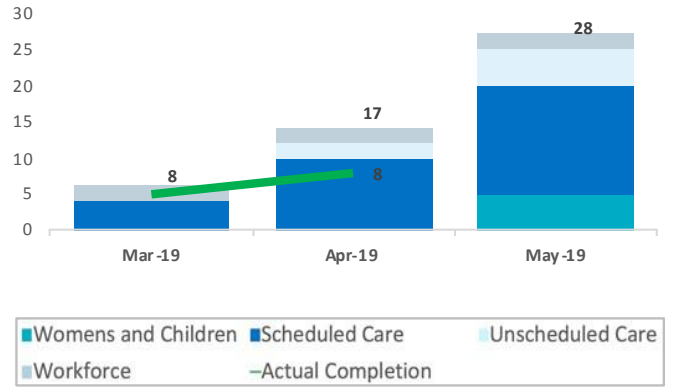


Figure 2: Should Do Root Cause completion, by month, selected months.



Although slightly delayed by Easter bank holidays, the Trust expects to recover this position through May. As the ISGs and QIPs mature, there is an expected level of revision to some plans. This is monitored on a weekly basis by the Executive Continuous Improvement Board. The approach to change control was detailed within the April update.

1b. ISG summary progress

This section sets out progress at an ISG level in greater detail.

Women's and Children's ISG

The Women and Children's QIP addresses the 21 Must Do and 27 Should Do findings relating to maternity services at the Trust. The unpacking process led to the identification of 47 Must Do and 35 Should Do Root Causes. Maternity actions detailed and required in response to the Section 31 notice have been incorporated within the Women and Children's QIP.

The ISG has made good progress to date, and at the end of April had achieved 85% of planned trajectory for Root Causes. 22 Must Do Root Causes had been closed, against a target of 26. During May there has been a concerted effort to complete Root Causes that were not done so on target, and a focus on implementing those due by the end of the month.

Scheduled Care ISG

The Scheduled care QIP addresses the 16 Must Do and 42 Should Do findings relating to Critical Care, Surgery and End of Life Care (EoLC) services. The unpacking process led to the identification of 45 Must Do and 68 Should Do Root Causes. While there is a high number of Should Do findings for Scheduled Care, some have already been unpacked through linked Must Do findings.

The ISG has made progress to date, and at the end of April had achieved 84% of planned trajectory for Root Causes. 21 Must Do Root Causes had been closed, against a target of 25. During May there has been a concerted effort to complete Root Causes that were not done so on target; there is evidence that this focus may not fully recover the trajectory.

Unscheduled Care ISG

The Unscheduled care QIP addresses the 20 Must Do and nine Should Do findings relating to the Emergency Department (ED), Medicine and Hospital at Night teams at RSH and PRH. The unpacking process led to the identification of 68 Must Do and 23 Should Do Root Causes.

The ED and Medicine actions detailed and required in response to their Section 31 and Section29a notices have also been incorporated with the Unscheduled Care QIP. Further requirements from the recently received Regulation 31 enforcement notice will also be built into plans.

The ISG has made progress to date, and at the end of April had achieved 67% of planned trajectory for Root Causes. 16 Must Do Root Causes had been closed, against a target of 24. During May there has been a concerted effort to complete Root Causes that were not done so on target. It is unlikely that there will be a full recovery against trajectory.

Workforce ISG

The Workforce QIP addresses the 21 Must Do and 10 Should Do findings relating to staffing and training findings across the Trust. The unpacking process led to the identification of 105 Must Do and 16 Should Do Root Causes. These include Section 29A Notice actions relating to safe staffing levels and training in ED and Critical Care.

The ISG has made good progress to date, and at the end of April had achieved 87% of planned trajectory for Root Causes. 34 Must Do Root Causes had been closed, against a target of 39. During May there has been a concerted effort to complete Root Causes that were not done so on target, and a focus on implementing those due by the end of the month.

1c. QIP examples of progress

ISGs frequently monitor progress by considering the impact that changes and improvements delivered, or in progress, have on patient experiences and outcomes. The two examples below are taken from the Unscheduled Care ISG, and are illustrated with patient feedback:

Figure 3: Improvements as a result of changes to Children's streaming in ED

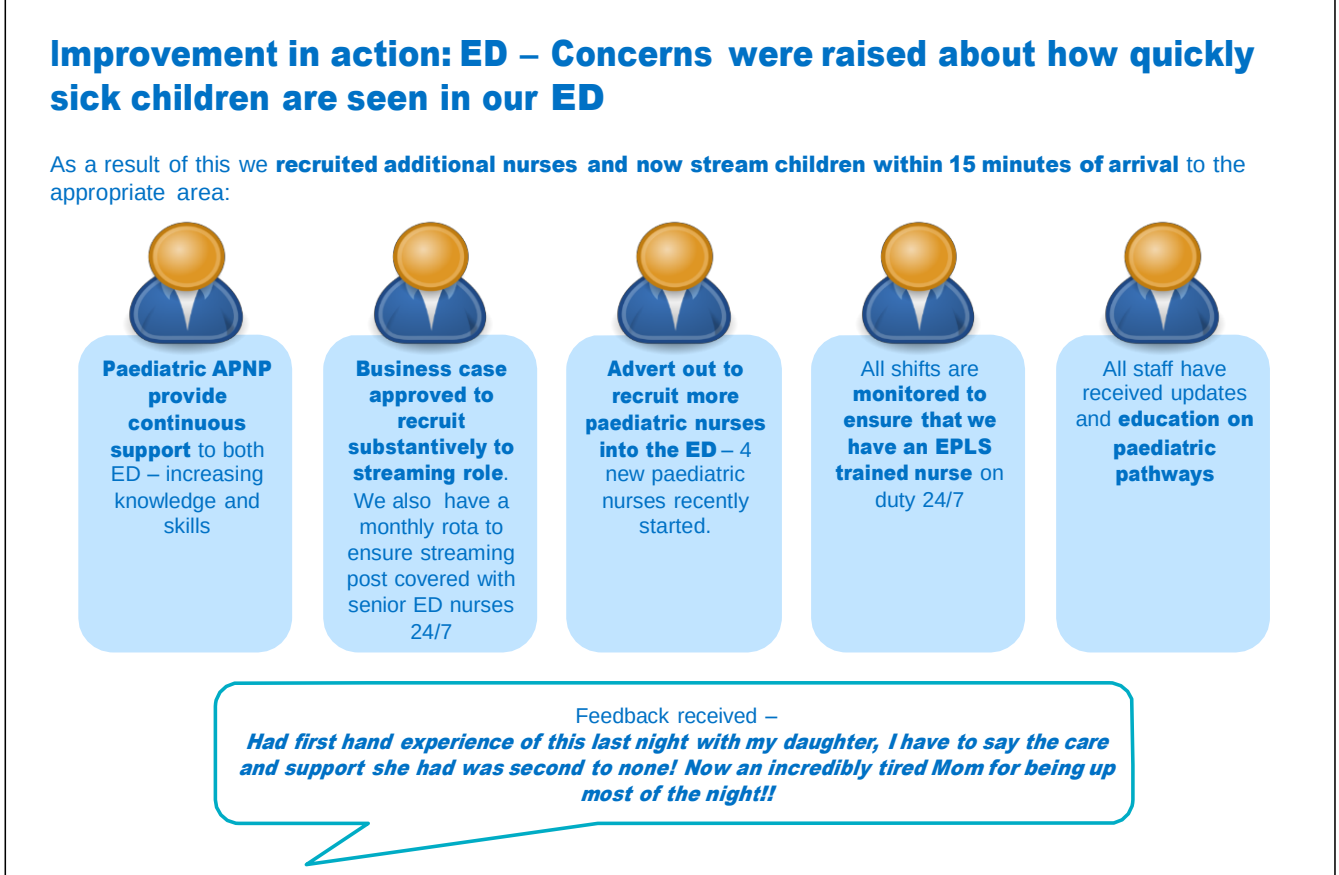
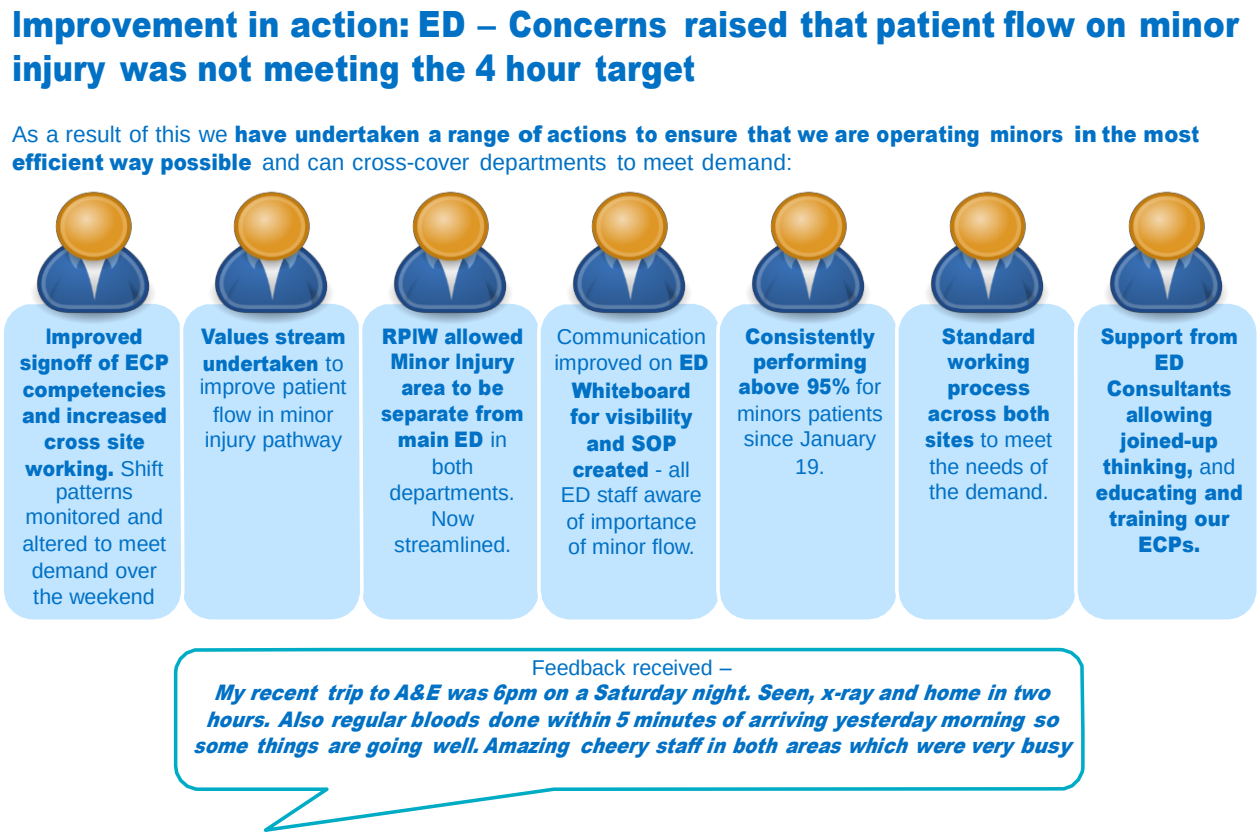


Figure 4: Improvements as a result of changing patient flow in minors



2. Well-led improvement plan

This section outlines the progress made in the development and operationalisation of the Well-led improvement plan. This is overseen by the Well-led ISG, in common with other elements of the QIP, but reports to a monthly cycle, as opposed to a fortnightly 'sprint'.

2a. Plan status

The full Well-led improvement plan was signed off by the ISG at the end of April. This plan differs from other QIPs and is structured around the CQC's eight KLOEs. The CQC uses these KLOEs and their constituent prompts as a guide to determining the Well-led rating.

The recommendations and findings from prior reviews (including the most recent by the CQC) are reflected throughout the plan. A number of key common themes have emerged from the reviews previously undertaken. These themes underpin the approach to well-led improvement:

- Organisational culture
- Governance of the organisation
- Engagement
- Developing capability
- Leadership capacity

Organisational performance is impacted by all five themes. The themes also cut across the eight KLOEs within the Well-led assessment framework.

The Well-led ISG maintains oversight of progress against the plan, and in common with other ISGs is accountable, via the Accountable Executive, to the Executive Continuous Improvement Board.

2b. Progress to date

In line with the timelines set out in the previous update to Board, the Well-led improvement plan has been in development through April. Reporting against the plan will formally begin in May. However, there has been significant effort to implement the recommendations of prior reviews and other initiatives. As a result, the Trust does not begin from a 'standing start', rather improvements in this area build on existing foundations.

There is demonstrable progress against all KLOEs in the Well-led domain. Three summary examples against the following KLOEs are shown below:

- W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?
- W3: Is there a culture of high-quality, sustainable care?
- W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Figure 5: Actions underway, how impact will be evidenced and future plans for KLOE W1

Key line of enquiry	Actions over the past month	How we will evidence the change	Future plans
W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?	• Executive Director portfolios and job descriptions reviewed and re-aligned	• Letters sent to all Executives • New role of Director of Clinical Effectiveness created to redistribute some portfolio responsibilities	• OD plan sent for Trust Board approval in May, with implementation commencing upon approval • Tier 2 committees will also use the revised agenda format based around BAF risks • Formal programme of Executive Genba walks • Outcome of review of NED diversity review with recommendations presented to Trust Board
	• Development of Leadership Academy (200 leaders have individualised development identified)	• All leaders will have a personalised development plan, based around self-assessment 	
	• SLT format update to improve effectiveness, 12 month SLT development plan agreed and implemented	• There are a greater number of senior leaders across the organisation involved in decision-making	
	• 12 month Board Development plan agreed and implemented	• Clear objectives set for the Trust Board for the coming year, including identification of areas for significant discussion	

Figure 6: Actions underway, how impact will be evidenced and future plans for KLOE W3

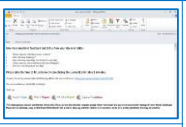
Key line of enquiry	Actions over the past month	How we will evidence the change	Future plans
W3: Is there a culture of high-quality, sustainable care?	• First pulse survey undertaken to understand staff perceptions, closed 28/04/19	• Three minute survey sent to all members of staff 	• Proposed Employee Assistance Programme which will enhance our wellbeing offer to be presented to workforce committee • Guiding Board for Think On will identify key organisational priorities that will be supported by Think On Coaches • Three People managers workshops planned (270 attendees) who will learn the Think On tools to support purposeful conversations • The OD strategy to be progressed to Board
	• 20 Freedom to Speak up Advocates recruited to support the Freedom to Speak Up Guardians	• In addition one Non-Executive Director has been identified as a Freedom to Speak Up Lead	
	• 50 Engagement Champions recruited, a volunteer role to share messages throughout the organisation	• Information is being shared from across the different Improvement Steering Groups and broader supportive Trust initiatives	
	• 22 'Think on' Master Coaches recruited	• Master Coaches will be advocates of 'purposeful conversations' and changing the dialogue throughout the organisation	
	• Ten Peer-to-Peer listeners	• Greater capacity for listening to staff	
	• Staff focus groups have been held, an opportunity for staff voices to be heard	• Implemented the Chief Executive's cascade as a result of feedback • CEO Breakfast sessions scheduled through 2019/20 	
	• Approval of a six month OD Delivery Plan at Trust Board	• Monthly updates to Workforce Committee	
	• Our Improving Together newsletter has launched, sharing news of improvements made across the organisation	• Newsletter shared across the organisation to celebrate the hard work being undertaken through the QIP	

Figure 7: Actions underway, how impact will be evidenced and future plans for KLOE W4

Key line of enquiry	Actions over the past month	How we will evidence the change	Future plans
W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?	• The Board Assurance Framework has been revised and refreshed, and and there is now more focused discussion at Tier 2 Committees	• BAF now frames our discussion at tiered committees 	• Care Group governance review and alignment with Board committees (including agenda format) • Serious Incident panel to be established • Workforce Committee effectiveness reviewed and forward-view work plan implemented • Review and restructure of Clinical Governance Executive following Committee Review • New Board Levels roles agreed - Director of Strategy & Transformation, Director of Clinical Effectiveness, Chief Communications Officer, Chief Information Officer, two Deputy Directors of Nursing (previously one), Deputy CEO.
	• Implementing the recommendations contained in the Deloitte audit on Tier 3 committees	• Refreshed committee structure (*in following section*) 	
	• Expanded Terms of Reference of Audit Committee	• Audit Committee now receives assurances on the structures and processes to support: whistleblowing, robust data quality and clinical audit.	
	• Establishment of Maternity Oversight Group chaired by a non-executive Director, a sub-committee of the Trust Board	• Chaired by the Trust Chairman, enabling direct access from the Maternity service to the Board	
	• Agreement to establish ED Oversight Group chaired by a non-executive Director, that will take a similar form to the Maternity equivalent	• Will ensure Board-level oversight of an identified risk area for the organisation	
	• Agreement to establish Recruitment and Retention Group, to be chaired by a Non-Executive Director	• Increased oversight and focus on addressing an identified risk area for the organisation	
	• Risk management training and report writing workshops have been provided to over 100 managers in both categories since November	• Improved quality of 'inputs' into governance and committees, increased consistency of risk and reports	

3. Measuring the impact of QIPs

This section outlines our approach to measuring the impact of the QIP, how assurance will be provided that that the actions undertaken are the right ones, and that patient safety, experience and outcomes are being improved.

3a. High-level KPIs

We have been working to identify a selection of high level KPIs for each ISG built from multiple sources. Our approach has included:

- Reviewing the CQC KLOEs and constituent prompts, considering the underpinning evidence
- Comparing potential KPIs with peer and outstanding organisations
- Reviewing a series of metrics suggested by NHS Improvement in Maternity and ED.

This approach has been taken to ensure that the metrics we use are sufficiently evidence-based, do not place undue burden on the organisation, and are recognisable. High-level KPIs are not tied to an individual action or Root Cause, rather they are intended to provide a view on whether the combined actions (both through the QIP and other tactical changes) are delivering overall improvement.

We have identified between 10-20 high level KPIs for each ISG. These have been agreed within ISGs and have been selected to represent performance across the five CQC domains.

3b. Root Cause KPIs

In addition to the high-level metrics, for each Root cause (both Must Dos and Should Do) a KPI has been identified. These have been developed by the ISGs as a part of plan development and agreement.

Root cause owners will be reporting against this KPI as part of the fortnightly reporting cycle. Trending data will be provided to ISGs to monitor ongoing performance. The aim of these KPIs is to provide assurance that the identified actions to address the Root Cause have had the intended impact. Where this is not evident, then ISGs will review actions and potentially identify new actions to ensure required improvements are embedded.

4. Managing and assuring our progress

This section will provide an update on how the QIPs are overseen and consolidated to provide an overall summary of progress, and the impact of this, across the Trust. This is supported by a series of integrated dashboards, that were presented to the Board as part of the April update. Significant progress has been made to recruit and transition to a substantive Programme Management Office (PMO) team and reducing reliance on external support.

4a. Improving Care PMO

We have commissioned external support to enable development of the QIP plans and the oversight governance and reporting. The ambition has always been to transition this support into a sustainable, substantive team. This team will continue and build upon early successes in delivering the QIPs.

In addition to overseeing and reporting on QIP progress, it is proposed that the Improving Care PMO will have a wider role as the single point of contact for all CQC-related information, and the route through which information passes. This will ensure the consistency of messaging and that all information is uniformly assured. This will reduce the burden on the organisation, whilst aiming to increase the already high quality of outputs.

Clear transition plans have been enacted to ensure that PMO activities are not impacted as external support ramps down and the substantive team is recruited into post. There will be close working arrangement with the other key priority PMOs (including Waste Reduction PMO and the Kaizen Promotion Office (KPO)), and virtual team working with Care Groups, Workforce and Corporate Nursing.

4b. Addressing cross-cutting themes

Further to the update provided at the April Board, further work has been undertaken to agree the approach and governance oversight of cross-cutting themes. These are: *improvements identified within one service, but that require changes to be made by a corporate or clinical support service.* These will result in an organisation-wide impact.

The development of an additional ISG to oversee these themes was explored, but ultimately discounted. However, a task and finish group has been convened to oversee progress and provide updates to the Unscheduled Care ISG (where the majority of cross-cutting actions sit). This includes representation from Root Cause owners, the Corporate Nursing team and the KPO. The task and finish group is Chaired by the Deputy Director of Nursing.

Progress against the cross-cutting themes is reported through Unscheduled Care ISG, as detailed in the section above.

5. Engagement

This section provides a summary of the approaches that are taken to ensure that patients and the public, our staff and our system partners are engaged in the QIPs. Ongoing, effective engagement is a core enabler of the overall QIP. It is overseen by the Engagement and Enablement Group.

5a. Patients and the public

The Patient Experience Strategy guides our approach to engagement with patients and the public. The strategy has two key objectives:

- To listen to our patients and their families so we learn how to improve the care we provide
- To collaborate with patients and other community partners in designing, monitoring and improving the care we provide.

The impact of change delivered though QIPs is measured, where possible, through how they improve patient experience and outcomes. The Patient Experience Strategy is in the process of being refreshed, as part of a separate piece of work, and will continue to inform the approach.

5b. Staff

As outlined in the April update to Board *"The engagement of staff from ward-to-Board has been pivotal to the development of the QIP… Staff engagement is a key dependency for achieving sustainable embedded improvement. For this reason, staff knowledge and engagement in improvement is a key indicator tested by the CQC during engagement."*

As outlined above, all engagement is overseen and assured by the Engagement and Enablement Group. This recently sought to identify a number of Engagement Champions (ECs) , to support with the sharing of information about the ISGs and QIP across the organisation. These roles enable two-way conversations, both sharing key information about the QIP and providing live feedback. Engagement Champions volunteer their time to undertake the role. The Engagement and Enablement Group recently advertised the role across the organisation to seek volunteers; to date, around 80 volunteers have been identified and induction is in progress.

In addition, the Engagement and Enablement Group has overseen the launch of the *Improving Together* newsletter. This is published on a monthly basis and contains a summary of all improvement work, as well as headlines from each ISG. This is sent via email to all staff and printed versions are available throughout the Trust, aimed at those without Trust email access or who are visiting. A summary is shown in Figure 8 below.

Figure 7: Selected pages from the Improving Together newsletter

5c. System partners

The monthly SOAG remains as the main recurring forum within which the Trust engages with system partners and provides an update on the progress of the QIP. At this forum there is time set aside on each agenda for partner feedback. The Trust works closely with NHS England and Improvement to agree an agenda that provides sufficient opportunity for assurance and discussion.

In addition to SOAG, there are other forums such as the Commissioner Quality Review Meeting (CQRM) where the Trust interacts directly with system partners with a quality focus. Further opportunities to maintain an open and transparent dialogue are being identified.

6. Preparation for CQC inspection

This section sets out the proposed approach that the Trust will take for the next CQC inspection. As set out in the April update to Board, there are clear timelines for the frequency of CQC inspection, which is dependent in part on the outcome of the most recent inspection (i.e. services rated inadequate must be inspected again within one year).

External support had been commissioned to undertake CQC inspection preparation during May and June. Given the likelihood of the next CQC inspection happened later in the year (note that this timeline is outside of the Trust's control), it was agreed that accessing support for preparation at this time would not provide value.

It is therefore planned that external support will be engaged later in the year to provide guidance and provide assurance of preparations ahead of the CQC inspection. The aim of this support will be to bring best practice and tools from other organisations to ensure that all parts of the organisation are able to demonstrate improvements made effectively over the prior 12 months and articulate the journey towards becoming an outstanding organisation.

Recommendation
The Trust Board is asked to: • **Note** the progress that has been made in the delivery of QIPs against the previously approved trajectories by the five ISGs throughout April, and the plans to maintain momentum. • **Note** the approach to the development and monitoring of metrics that will measure the impact of improvements. • **Note** the approach towards engagement with patients and the public, our staff, and system partners, and the role of all within the organisation in support of this. • **Note** the progress of embedding a substantive team to take forwards the QIP and **approve** the arrangements for preparation ahead of the next CQC inspection.